Date: July 17, 2000 DSL-BQA-00-050

To: Home Health Agencies HHA - 16
Hospices HSPC - 19

From: Otis Woods, Section Chief
Health Services Section

Via: Susan Schroeder, Director
Bureau of Quality Assurance

HCFA Informational Releases:

#2000-12, Questions and Answers regarding Hospices

#2000-16, Change of Ownership, Merger, and Termination Procedures Affecting HHAs and OASIS Requirements

Attached are two informational releases from HCFA, sent to the Bureau of Quality Assurance (BQA) as Electronic Regional Program Letters. BQA is forwarding them to you for your information.

If you have further questions about #2000-12, Question and Answers regarding Hospices, you may contact:

Barbara Woodford, Nurse Consultant, Provider Regulation and Quality Improvement Section (PRQI) at (608) 266-7474.

Juan Flores, Supervisor, Southern Team, Health Services Section (HSS) at (608) 261-7824.

Jane Walters, Supervisor, Northern Team, Health Services Section (HSS) at (608) 267-7389.

If you have further questions about #2000-16, Change of Ownership, Merger, and Termination Procedures Affecting Home Health Agencies (HHAs) and Outcome and Assessment Information Set (OASIS) Requirements, you may contact:

Karen Turnure, PRQI Licensing/Certfication Leadworker, at (608) 266-7782.

Andrea Henrich, OASIS Education Coordinator, PRQI, at (608) 267-3807.

HEALTH CARE FINANCING ADMINISTRATION

Chicago Regional Office, Midwest Consortium
Electronic Regional Program Letter #2000-12

DATE: April 26, 2000

FROM: HCFA, Chicago Regional Office
Division of Survey and Certification

SUBJECT: **Questions and Answers regarding Hospices - INFORMATION**

TO: State Survey Agency Directors

The purpose of this memorandum is to inform you that HCFA recently provided the following answers in response to questions submitted from the Hospice Association of America at the National Association for Home Care's Policy Conference on April 3rd. We are including them for your files.

1. Q. Have there been any changes in the Skilled Nursing Facility/Nursing Facility (SNF/NF) regulations this year or current problems that hospice programs should be aware of in providing hospice services to residents of long term care (LTC) facilities?

1. A. There have been no changes to the SNF/NF requirements at 42 CFR 483(ff) this year. However, we remain concerned about the care that some residents who elect the hospice benefit are receiving.

   We added guidance to surveyors of LTC facilities several years ago that mirrors the guidance we have for hospice surveyors. Specifically, the State Operations Manual (SOM) for LTC surveyors states that surveyors will review the care of a resident receiving hospice care. When a facility resident has elected the Medicare hospice benefit, the hospice and the nursing facility must communicate, establish, and agree upon a coordinated plan of care for both providers which reflects the hospice philosophy, and is based on an assessment of the individual's needs and unique living situation in the facility.

   Surveyor's major concerns with hospice care in the LTC facility include the following:

   1. The provision of care and services which does not reflect the hospice philosophy.

   2. Problems with the coordination, delivery and review of the plan of care between the hospice and the LTC facility.

   3. Ineffective systems in place to monitor/assure that the plan of care is meeting the resident's needs in the area of pain management and symptom control.

4. Poor communication between the hospice and nursing home staff:

   - nursing home staff are often not aware of the hospice philosophy;
   - plan of care does not reflect the hospice philosophy or adequately address pain management and symptom control; and
   - hospice and LTC staff do not communicate problems encountered with the pain management assessments and make needed revisions to the plan of care in an effective and timely manner.

2. Q. If a hospice program has adopted the National Hospice Organization's (NHO) standards of care, which state that the hospice social worker is an MSW and the hospice program has employed a BSW, can the hospice be cited?

2. A. We expect that hospices will develop their policies and procedures, and we expect that they will follow them. The Federal requirement for a social worker is for a BSW, which is less stringent than the NHO standards. So the hospice is in compliance with the Federal requirement for social work, but the larger issue surrounds the hospice's failure to follow its own policies/standards. If the hospice tells the surveyor that their policy follows the NHO standards for an MSW and the surveyor discovers that this is not true, it is a finding.

   Surveyors will look at the total picture during a survey and observe the hospice's total operations. They will also review their survey "findings." This particular finding could in fact lead to a citation under the governing body--which is charged with assuming responsibility for determining, implementing and monitoring the hospice's policies.

3. Q. What are the top ten survey problems?

3. A. The ten most frequently cited tags include regulations pertaining to the development and updating of the plan of care and required records:

L137 - Plan states scope and frequency of services needed	16.18%
L136 - Plan includes assessment of individual needs	14.07%
L135 - Plan is reviewed and updated at intervals	12.01%
L134 - Plan established prior to providing care	10.74%
L210 - RN visits the home site at least every 2 weeks	9.07%
L133 - Written plan of care established	8.94%
L200 - Plan of care for bereavement service	7.67%
L209 - Home health aide and homemaker services available	6.97%
L211 - RN prepares written instructions for home health aide	6.40%
L185 - Record contains documentation of all services	6.36%

4. Q. A hospice program is admitting patients and awaiting their initial survey. Should the hospice program have these patients sign a Medicare benefit election statement during the admission process even though the hospice is not certified to offer the Medicare benefit at that time?

4. A. No. The Medicare beneficiary can only elect hospice from a Medicare approved hospice. A hospice awaiting its initial survey is not Medicare approved.

5. Q. During an initial hospice survey the hospice program was told that "your program is responsible for paying for all of the medications for the hospice patients". Is that correct?

5. A. Until a hospice is Medicare approved; it would not be expected to pay for the required drugs for Medicare beneficiaries. We would also like to note that the condition of participation at 42 CFR 418.56 requires the Medicare approved hospice to maintain professional management responsibility for the services it provides under arrangement. The standard at 42 CFR 418.56(d) requires the hospice to retain responsibility for payment for those services. A Medicare approved hospice is reimbursed for all covered services it provides, whether directly or under arrangement. It is the responsibility of the hospice to pay for those services provided to Medicare beneficiaries under arrangement. When a hospice provides services under arrangements to non-Medicare beneficiaries, the hospice is responsible for establishing how payment for those services will occur, but the standard does not require the hospice to pay for those services directly or to pay for services for which there is no reimbursement or for which another insurer is obligated to pay.

6. Q. A three program agency (HHA/hospice/ private pay) provides services in a several hundred square mile rural area. Can this agency share its staff to cover on-call service for all three programs?

6. A. If the staff are all employed by one corporation or organization, and that organization is responsible for issuing the W2 form on their behalf, employees could divide work time between the parent organization and the hospice or HHA if they were also appropriately trained to do the work. The hospice and the HHA need to maintain a record of the individual's assigned time to each program. However, if these ? corporate? employees provide services to the HHA or hospice outside of their own usual working hours or shifts (i.e., "moonlight" as HHA or hospice employees, as opposed to working overtime for the corporation,) they would be considered contract employees and would not meet the core service requirement for hospice or the direct service requirement for HHAs.

7. Q. Can an HHA and hospice use contract nurses to staff the agency’s on-call needs if the contract nurse is functioning in the role of “answering service only” for hospice calls?

7. A. A hospice cannot use a contract nurse unless it is to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances (e.g., half the nursing staff is out with the flu.) These circumstances are unexpected and for a finite period of time.

An HHA may use contract nurses if nursing is not the one service that it provides in its entirety directly by its own employees.

8. Q. A Medicare hospice patient is receiving support service through the State's home and community-based care (HCBC) program. The services are for home health aides for personal care and related support. Currently, the state HCBC programs nurses are approving the delivery of this care, through the waiver program. Is this double-dipping?

8. A. States have often argued that providing personal care services is duplicative to the home health aide and homemaker services that must be provided under the hospice benefit. The hospice is required by federal regulation to provide the home health aide and homemaker services in an amount that is adequate to meet the needs of the patient. These needs are determined by the hospice interdisciplinary team and should be noted and a part of the plan of care provided by the hospice.

To prevent duplication of services, it is up to the State to define the Medicaid personal care services option benefit and to determine if the benefit is more extensive than the homemaker/ home health aide benefit provided under the Medicare hospice benefit. If the personal care benefit is more extensive than what is offered under the Medicaid hospice benefit, then the State must pay for these services when a need for such services is indicated in the hospice patient's plan of care.

9. Q. Over the years a variety of clarification memos have been released, how and where can a new hospice program access this information so they can provide the correct information when issues arise during a survey.

9. A. We have developed a web site specifically for hospice material related to survey and certification issues. This site contains our recent memos, frequently asked questions, as well as links to the regulations and State Operations Manual. This web site can be accessed at www.hcfa.gov/medicaid/hospice/hospice.htm.

If you have any questions about this, please contact your Principal Program Representative.

/s/
Charles Bennett, Branch Manager
Survey and Certification Program
Coordination and Improvement

HEALTH CARE FINANCING ADMINISTRATION

Chicago Regional Office, Midwest Consortium
Electronic Regional Program Letter #2000-16

DATE: June 5, 2000

FROM: HCFA, Chicago Regional Office
Division of Survey and Certification

SUBJECT: Change of Ownership, Merger, and Termination Procedures Affecting Home Health Agencies (HHAs) and Outcome and Assessment Information Set (OASIS) Requirements -INFORMATION

TO: State Survey Agency Directors

The purpose of this regional letter is to provide oversight guidance for OASIS implementation in three situations: where an HHA undergoes a change of ownership with a merger of two or more agencies; where there is a change of ownership with and without assignment of the seller's provider agreement; and where there is termination of the provider agreement.

As part of Health Care Financing Administration's (HCFA) effort to achieve broad-based improvements in quality of care furnished by HHAs through Federal programs, OASIS is one of the most important aspects of the HHA's quality assessment and quality improvement efforts. The OASIS will assist agencies in improving their performance through quality of care determinations which are expected to be provided in Outcome-based Quality Improvement (OBQI) reports currently under development. As the individual patient assessments are linked to the individual HHA by their provider number, the OBQI reports will also be linked to the individual HHA by the provider number.

It is imperative that the provider number be accurately reported on the OASIS assessments in all reports, including when HHAs undergo change of ownership, merger, or termination.

Change of Ownership - Mergers

In accordance with 42 CFR Part 489.18 and SOM 3210, the merger of a provider corporation into another corporation constitutes a change of ownership. In the case of the merger of Agency A into Agency B, Agency A's provider agreement and its associated provider number are terminated. Agency B retains its existing provider agreement and provider number.

Agency A should provide the OASIS discharge comprehensive assessment for each discharged patient prior to or at the effective date of the merger. The surviving HHA (Agency B) should provide a Start of Care (SOC) comprehensive assessment for all persons it admits after the merger at the next skilled visit after the official merger date. The SOC assessment will allow eligibility for the home health benefit to be verified and care planning for the individual to proceed under Agency B. Subsequently, the assessments for all individuals being accepted for care by Agency B will be linked to the correct provider number to enable the agency to engage in quality improvement efforts with accurate OBQI reports.

Change of Ownership with Assignment

In accordance with 42 CFR Part 489.18 and SOM 3210, when there is a change in ownership and the new owner accepts assignment of the existing provider agreement, the new owner is subject to all the terms and conditions under which the existing agreement was issued, including compliance with the comprehensive assessment of patients condition of participation. The provider number remains the same if the new HHA owner accepts assignment of the existing provider agreement. The new owner is responsible for continuing to complete updates to the comprehensive assessment at the next scheduled time points.

Change of Ownership without Assignment

In accordance with 42 CFR Part 489.18 and SOM 3210, when there is change of ownership and the new owner rejects this assignment of the provider agreement, the provider agreement and provider number of the former owner should be terminated. The HHA that is terminating its provider agreement and provider number should provide an OASIS discharge comprehensive assessment for each patient subject to OASIS standards prior to the effective date of the termination, according to 42 CFR 484. The new HHA will not be able to participate in the Medicare program without going through the same process as any new provider, which includes an initial survey. The HHA should meet all the Federal requirements, including applicable OASIS requirements as specified in the regulations, for all persons it accepts for care in order to participate in the Medicare program. This means that the HHA should provide a new SOC comprehensive assessment at the first skilled visit once it becomes Medicare-approved. In addition, updates to the comprehensive assessment should be provided at the other OASIS time points, in accordance with 42 CFR Part 484, for all patients of the former owner it accepts for care.

Voluntary Terminations

In accordance with 42 CFR Part 489.52 and SOM 3046, a Medicare approved HHA may voluntarily terminate its provider agreement by filing a written notice of its intention to the State Agency who, in turn, notifies the Regional Office. HCFA recommends the HHA that is terminating its provider agreement should provide a discharge comprehensive assessment for each patient prior to the effective date of the termination.

Involuntary Terminations

The Regional Office may terminate an agreement with an HHA, in accordance with 42 CFR 489.53. HCFA will work with the HHA on a case-by-case basis to provide for the safe and orderly transfer of patients to another Medicare-approved HHA if appropriate.

The agency to whom the patients are transferred should provide a new SOC comprehensive assessment as well as updates to the comprehensive assessment at the other OASIS time points.

The guidance and recommendations provided in this memorandum apply to all accredited HHAs that participate in Medicare and to HHAs that are required to meet the Medicare Conditions of Participation, including Medicaid HHAs.

If you have any questions or concerns about this regional program letter, please contact me.

/s/
Charles Bennett, Branch Manager
Survey and Certification Program
Coordination and Improvement